

2010 BILLER "B" AWARE INFORMATION

December 21, 2010- **Attention Inpatient and Outpatient Providers:** As per MDCH policy bulletin MSA 10-46, MDCH has received approval for institutional crossover files starting December 9th, 2010 for inpatient and outpatient hospital claims. Once payment is received from Medicare and the MA07 remark code appears on the Medicare RA, providers should expect to see the claim appearing on the Medicaid RA within 30 days. The first two characters of the TCN will be 32. If the claim does not appear in CHAMPS within 30 days, a claim should be submitted directly to MDCH showing all of the Medicare payment information. For more information regarding Institutional billing instructions and to access the crossover frequently asked questions (FAQ), providers may review the MDCH website at www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Medicare Crossover.

December 1, 2010- **Attention: Nursing Facilities, County Medical Care Facilities, Hospital Long-Term Care Units, Hospital Swing Beds, Ventilator Dependent Care Units, Hospice, and Home Health Agencies:** Please see the following document regarding [Incorrect reporting of Other Insurance or Medicare on claims to Medicaid.](#)

November 29, 2010- **Attention Nursing Facility Providers:** All Provider rates were updated in CHAMPS. Providers can submit adjustment claims for October 2010 dates of service to receive the difference.

November 23, 2010- **Attention ALL Providers: Claims Denied with REASON Code (CARC) 96 and Remark Code (RARC) N35.** As a reminder, if your claim status shows IN PROCESS in CHAMPS, **DO NOT** resubmit another claim. MDCH will be clearing these duplicate suspending claims off of the system on an on going basis, keeping only the most recently submitted claim that is suspending. You will see these claims on your Remittance Advice denied with Reason code 096/Remark Code N35. Do not resubmit those claims. If you get this denial, please do a search in claim inquiry on CHAMPS to find the additional claims.

November 20, 2010- **Attention ALL Providers:** We have identified an issue with claims sent on 11/08/2010. They appear to be randomly processing as a denied claim for "limits exceeded"; with no original pay date. These claims should be released by next pay cycle.

October 26, 2010- **Attention ALL Providers:** MDCH has identified a system issue with providers that have multiple specialties on file within CHAMPS. The issue has affected approximately 40,000 claims. These claims are incorrectly denying with Reason Code (CARC) 185 and Remark Code (RARC) N198 or the claims are not paying at the correct rate. MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of providers.

October 21, 2010- **Attention All Providers:** Effective October 15, 2010 MDCH is reporting the following additional Managed Care Benefit Plans for Providers in the CHAMPS eligibility screen and 270/271 transactions.

PIHP (Prepaid Psychiatric Inpatient Health Plan)
SA (Substance Abuse)
CMH (Community Mental Health)
CSHCS-MH (Children's Special Health Care Services, Medical Home)

Medicaid Managed Care (MA-MC) and Adult Benefit Waiver Managed Care (ABW-MC) continue to be provided on the eligibility screen and 270/271 transactions. Please ensure that you are utilizing the correct contact information associated with the appropriate benefit plan.

Please see the Benefit Plan Handout listed on our CHAMPS Resources page for additional definitions of these plans. <http://www.michigan.gov/medicaidproviders> >>CHAMPS. You can find the full plan descriptions in the Medicaid Provider Manual <http://www.michigan.gov/medicaidproviders> >> Policy and Forms>> Medicaid Provider Manual.

September 14, 2010- **Attention PDN Providers: IMPORTANT NOTICE:** Effective October 1, 2010, the Michigan Department of Community Health (MDCH) will require Private Duty Nursing (PDN) providers to bill HCPCS codes S9123 and S9124 in one-hour increments as required in the 2010 HCPCS coding book. PDN services are prior authorized in hours. Therefore, when billing for services, the total number of hours billed - whether with S9123 and/or S9124 - must not exceed the total number authorized for that month. **Since whole hours of care are authorized, only those hours of care that entail a full hour of care may be billed.**

Please Note : Authorization letters for the month of October will authorize care in units but the quantity will reflect the number of hours approved for the month. **One unit = one hour.**

Refer to Bulletin MSA 10-35 for further information.

August 26, 2010- **Attention All Providers:** Quarterly Newborn recoveries were temporarily suspended as of July 2009 while MDCH implemented the new CHAMPS system. Beginning with Paycycle 33, MDCH will resume the quarterly takeback/recoveries for newborn beneficiary claims that were paid FFS where the newborn is now enrolled in a Medicaid HMO. The first recovery batch will be to catch up for claims paid prior to 3/31/2009, and MDCH will continue these takebacks in subsequent paycycles for legacy claims paid between 4/1/2009 - 6/30/2009 as well as claims paid between 7/1/2009 - 9/30/2009. After these 3 catchup batches, the next regular quarterly scheduled takeback/recovery will resume on a quarterly basis in October 2010. Please note, as with previous quarterly newborn takebacks, claims must be submitted to the Medicaid Health Plans within 60 days from the Medicaid Remit Advice date.

August 11, 2010- **Attention IPH Hospitals:** MDCH recognizes that many hospitals have aging accounts currently suspending in CHAMPS that may affect their DSH and/or MIP reconciliations. IPH claims with dates of service prior to 1/1/2009 will be identified for priority processing over the next two weeks. If after the two weeks, hospitals still have additional outstanding aging accounts, hospitals may then contact ProviderSupport@michigan.gov with a listing of 25-50 TCNs for aging accounts that will be considered for priority processing. NOTE: Please only submit a list of the TCNs and as per HIPPA Privacy and Security guidelines, please do not send any Protected Health Information (PHI).

August 11, 2010- **Attention Outpatient Providers:** OPH claims with DOS on/after 7/1/2010 will no longer set the edit for "diagnosis code does not support procedure billed" when revenue code 450/452 is billed. Claim Adjustment Reason Code: 11 - The diagnosis is inconsistent with the procedure. Remittance Advice Remark Code: N10 - Claim/service adjusted based on the findings of a review organization/professional consult/manual adjudication/medical or dental advisor.

August 05, 2010- **Attention ALL Providers:** The error that began on July 24th that restricted the allowed amount quantity to one (1) unit of service per claim line regardless of the number of units billed or normally allowed for certain procedure codes **has been resolved** as of August 4th. Providers should no longer experience this issue for TCNs with Julian dates greater than or equal to 10216 (yyddd). MDCH is currently collecting the data necessary to reprocess the affected claims on behalf of providers. Providers may also adjust the affected claims.

July 26, 2010- **Attention Outpatient Providers:** MDCH has identified a systems issue with the APC software which caused some Outpatient claims to pay \$0 during the past week. Claims affected have been identified and will be mass adjusted by MDCH to correct the payment issue.

July 21, 2010- **Attention ALL Providers:** MDCH has identified an issue with a portion of the Outpatient legacy edit 743 Claims that were mass resurrected in CHAMPS in February. Some of these claims were not able to be successfully resurrected and will be denied with reason code 17/remark code N379 on the next two Remittance Advices starting with 7/15/10. Beginning in early August, MDCH will be re-resurrecting these selected denied claims to process correctly through CHAMPS.

July 07, 2010- **Attention Professional Providers:** Claims which denied for Invalid Admission Date have been reprocessed and will appear on the next RA.

July 07, 2010- **Attention Institutional Providers:** An issue has been identified for Inpatient hospital claims whereby CHAMPS is not recognizing PACER numbers submitted using the Qualifier G4 (Loop 2300 Ref Segment). This issue is being worked on and until it is corrected, all Prior Authorization and/or PACER numbers should be submitted using the 2300 REF Qualifier G1 for Admission/Readmission/Elective IPH stays until further notice on all electronic claim submissions.

June 23, 2010- **Attention All Providers:** Due to planned upgrades to the FileNet system, Remittance Advices for Pay Cycle 25 (June 24, 2010) will not be available until Friday June 25, 2010. Thank You.

June 10, 2010- **Attention Institutional Providers:** MDCH is currently working on an implementation plan for Institutional Crossover claims received directly from Medicare. We plan to have Institutional Crossovers in production by Fall 2010. The appropriate NPI for Medicaid adjudication must be reported on the initial claim sent to Medicare in order for the Crossover claim to adjudicate correctly in CHAMPS. MDCH will post additional information as it becomes available.

June 03, 2010- **Attention All Providers:** MDCH anticipates the next system update to occur on June 11th 2010. As a reminder, please do not re-submit claims if your claims are currently suspended in CHAMPS.

June 02, 2010- **Attention All Providers:** During the first week of April 2010, MDCH identified an issue with the way CHAMPS calculates a beneficiary's age during the adjudication of some claims. This issue was corrected, and while it did not impact the actual editing or pricing of the claims, it still required that certain claims with incorrect ages be reprocessed so that reporting and statistical claims data is accurate. MDCH has reprocessed the impacted claims to correct the age calculation and these adjusted claims should appear on your next RA.

May 26, 2010- **Attention All Providers:** MDCH would like to remind Providers when billing secondary claims to Medicaid to report the Claim Adjustment Reason Code(s) (CARC) reported by the primary payer. If the primary payer typically covers the service, however, indicates the service is non-covered (CARC 96), claim notes indicating why the service was not covered by the primary payer are recommended.

May 24, 2010 MDCH is currently processing newborn applications after 4/18/2010 into Health Plans.

May 24, 2010- MDCH is currently processing the Hospice Membership Notice (DCH1074) Forms received as of 05/03/2010.

May 24, 2010- **Attention All Providers:** Per MDCH Policy, providers that are submitting secondary claims on paper must submit the Allowed Amount as the Submitted Charges on the paper claim form. If the Submitted Charges are different than the Allowed Amount from the Explanation of Benefits (EOB), MDCH will reject the claims. Please refer to the Provider Manual, Billing & Reimbursement for Professional chapter, Section 3 Claim Completion instructions, for additional information. Due to the number of secondary paper claims and the processing time, MDCH encourages all providers to submit claims electronically. If you do not have a Billing Agent, MDCH offers the free Direct Data Entry (DDE) option directly in CHAMPS.

May 20, 2010- Attention All Providers: MDCH has identified over 56,000 duplicate suspending claims in CHAMPS since go live. These duplicates are a result of multiple provider submissions of the same claim. In the next week, MDCH will be clearing these duplicate suspending claims off of the system, keeping only the most recently submitted claim that is suspending. You will see these claims on your next RA denied with Reason code 096/Remark Code N35.

Please do not resubmit these denied duplicate suspending claims. As a reminder, if your claim is currently suspending in CHAMPS, please do not resubmit another claim as this will increase our backlog and the time it takes to get to resolving your initial claim.

May 19, 2010- Attention All Providers: MDCH urges Providers that send secondary claims on paper to consider submitting those claims using the CHAMPS Direct-Data-Entry (DDE) Claim Submission or through a Billing Agent using the 837 electronic claim format. Use of the DDE and/or Billing Agent offers several advantages including:

- Ø Eliminates the need to attach the Explanation of Benefits (EOB). DDE and the 837 allow other insurance payments to be reported using Claim Adjustment Reason Codes (CARC). In the CHAMPS DDE screens these codes are referred to as "Reason Codes." The CARC Codes can be found at www.wpc-edi.com/.

- Ø Claims that are submitted DDE will appear in CHAMPS within approximately 15 minutes

- Ø Claims received electronically on the 837 appear in CHAMPS the following day.

May 17, 2010- Attention All Providers: MDCH is currently developing a training webcast focused on Medicaid Trading Partners; specifically Medicaid Billing Agents or provider staff who transmit HIPAA 837 electronic claims directly to MDCH via the DEG or CHAMPS screens and who receive and translate HIPAA 835 electronic remittance advice and 277U electronic claims status (pending claims) files on behalf of Michigan Medicaid providers. The webinar is expected to be released in mid-to-late June and will be available on the CHAMPS informational website.

Billing Agents are encouraged to submit questions and topics that they would like MDCH to cover during the training. All questions/comments must be submitted to AutomatedBilling@michigan.gov by May 21st. The subject of the email must be "Webcast Questions/Comments - [Your Subject Here]".

A listserv message will be sent when the webcast has been released on the CHAMPS informational website.

May 13, 2010- Attention All Providers: In the event you receive a denial as the result of a Champs related defect, please resubmit your claim. When the claim exceeds the one year billing limitation, please include the TCN of the denied claim in the claim notes area.

May 13, 2010- Attention All Providers: The resubmission of "INPROCESS" claims is causing additional backlog for the claims processing unit. Claims with a status of "INPROCESS" in CHAMPS are pending for review. Providers should not rebill claims that are in this status as it will also pend or create a new "INPROCESS" claim.

May 12, 2010- Attention: Family Planning Clinics, FQHCs, Outpatient Hospitals, LHDs, Medical Suppliers, MH/SA, Nursing Facilities, Practitioners, RHC and THC providers: The implementation of the CHAMPS system allows MDCH to adjudicate claims compliant with the federal mandate requiring the National Drug Codes (NDC) for physician-administered drugs administered in a physician office, clinic, beneficiary home, local health department or outpatient hospital setting. MDCH policy was published effective for dates of service on or after July 15, 2007 for professional claims (MSA 07-33) and on or after July 1, 2008 for institutional outpatient claims (MSA 08-02). This information is available in the on-line MDCH Provider Manual at www.michigan.gov/medicaidproviders. In the CHAMPS system, if you bill a HCPCS code representing a physician-administered drug and your claim has one of the following conditions, then the service line will deny: service lines with an invalid HCPCS and NDC combination reported, service lines with an invalid or missing NDC at the service line and service lines with non-rebateable NDCs reported. The implementation of these edits has been phased in and will be fully operational by June 2010.

A denied service line on a claim will have these reason and remark codes:

Adjustment Reason Code	Remittance Remark Code
16 - Claim/service lacks information which is needed for adjudication	M119 - Missing/incomplete/invalid National Drug Code
181 - Procedure code was invalid on the date of service	
211 - National Drug Codes (NDC) not eligible for rebate, are not covered	

May 10, 2010- Attention Outpatient Providers: MDCH has begun reprocessing all Outpatient claims paid by CHAMPS to date. This reprocessing is to correct several system and OPH pricing issues that have now been resolved. PLEASE NOTE: MDCH will only be reprocessing those paid claims which result in a payment/processing correction - not every OPH claim that has been adjudicated by CHAMPS. Starting this week, MDCH has reprocessed all September and October pay cycles for these OPH claims and will begin working to adjust November/December claims with payment/processing differences in the upcoming weeks. Please check the CHAMPS Provider updates for more information.

May 5, 2010- Attention All Providers: Please be advised that the Third Party Liability will resume the Pending Claim Adjustment Report process in the near future. This will include both Medicare and Commercial claims.

April 28, 2010- Attention Providers Submitting Paper Claims: Paper claims are inherently less reliable than electronic claims because paper claims require manual human intervention to adjudicate the claims. The adjudication steps for electronic claims are all automated, uniform, and therefore much more predictable. MDCH encourages all providers to either submit electronic claims or utilize the CHAMPS Direct Data Entry Claim Submission in order to avoid the unexpected and unreliable outcomes associated with paper claim submissions.

April 28, 2010- Attention Nursing Facility Providers: A beneficiary who has a patient pay amount cannot legally be charged more than the Medicaid rate for a short stay in a facility. For example, if a beneficiary is in a long term care facility for two days in a month, the provider must collect no more than the Medicaid rate for two days from the patient pay amount (even if the patient pay amount is great enough to cover the higher private pay rate). The balance, or unused portion of the patient pay amount must be returned to the beneficiary or his family.

April 14, 2010- Attention CMH Providers: See Letter regarding: [CHAMPS SED Waiver; Children's Waiver Program \(CPW\) Payment Implications](#)

April 13, 2010- **Attention Outpatient Providers:** The March CHAMPS system update resulted in a new issue with some Outpatient claims. If a provider bills zero dollars on a line of an outpatient claim, the line will now pay zero instead of using the logic to take into account the dollars from the other lines. MDCH is working on resolving this error as soon as possible. Please continue to check this website for updates.

April 13, 2010- **Attention Health Plan Network Providers:** Providers who are both Medicaid enrolled and a health plan network provider can see both their claims AND encounters in CHAMPS. An encounter can be differentiated from a claim on the list page by looking at the Transaction Control Number (TCN). The first two characters of an encounter TCN will always begin with 33. If the provider clicks on the TCN hyperlink, the encounter will show a "Source" of HIPAA ENCOUNTER in the upper right hand corner. On the list page any Claim Status value of "Accept" or "Reject" indicates encounter (claims will never have these statuses).

April 1, 2010- **Attention Institutional Providers:** MDCH is now able to create the FD-622 report, dating back to the first pay cycle paid from CHAMPS (pay cycle 39). This report will be mailed to the correspondence address, on file within the Provider Enrollment application. MDCH is currently mailing the Outpatient and Inpatient reports separately until paycycle 43 (October). Please be aware that the initial FD-622 mailed for Inpatient providers was identified as Payroll 11, 3/18/2010 and contained payroll 11 information. This mailing sequence has been corrected and the report will now be mailed in date order (oldest to most recent). Beginning with paycycle 44 both the Outpatient and Inpatient reports will be sent in a single mailing. The FD-622 report for Long Term Care Facilities will be mailed in the near future. Please continue to check the website for updates.

April 1, 2010- **Attention Hospice Providers:** Recently hospice providers received a letter informing them of their seven-digit Medicaid Provider ID number in CHAMPS. This number is necessary when completing the Hospice Membership Notice, DCH-1074. Do not resend DCH-1074 forms to Enrollment Services Section (ESS) for the sole purpose of updating them with the new Provider ID number. This is not necessary and places an undue burden on the ESS causing a backlog of forms further delaying hospice enrollments.

March 30, 2010- **Attention Nursing Facility, Private Duty Nursing, Home Health, Hospice Providers:** MDCH would like to remind providers to verify the diagnosis codes being billed are valid ICD-9-CM and that the beneficiary's age is valid for the diagnosis code being billed.

March 9, 2010- **Attention Nursing Facility Providers:** After the implementation of CHAMPS, the systems edit between the Medicaid Nursing Facility Level of Care Determination (LOCD) and the CHAMPS payment system was disabled. The Michigan Department of Community Health has addressed the issues between the systems and is now ready to reactivate this edit. Please be advised that beginning April 1, 2010, the CHAMPS system will reinstate editing to ensure that the LOCD is conducted timely and in accordance with Medicaid policy, which can be found in the Medicaid Provider Manual, Nursing Facility Chapter, Section 4.1D.

March 4, 2010- MDCH is currently completing the gap analysis and planning for the HIPAA 5010 and ICD-10 project. MDCH expects to follow the Industry timeline and is targeting for a January 1, 2011 external trading partner testing date. The HIPAA 5010 mandate for Production transactions is January 1, 2012. MDCH will provide additional information regarding testing after the analysis has been completed. Please review the MDCH website for additional updates.

March 2, 2010- **Attention All Providers:** MDCH would like to remind Providers that only approved claims can be adjusted. A claim is considered approved if at least ONE line paid, and paying \$0.00 is considered a paid claim. Claims that have previously paid should not be resubmitted as a new claim in the system, but rather submitted as an adjustment if a change is necessary or reprocessing is in order. Claims will deny for duplicate if incorrectly submitted as a new claim rather than an adjustment claim.

March 2, 2010- Attention Home Health Providers: The Medicaid Payments Division has been seeing a large number of Home Health Agency claims for Procedure Code G0154 (Nurse Visit), that appear to be exact duplicates of a previous claim. Beginning March 1, 2010, these duplicate claims will reject with the appropriate Reason and Remark code(s). Note: If billing for more than one nurse visit on the same date of service you must bill each visit on an individual claim line, on the same claim. Duplicate claims for services on the same date of service will be rejected.

February 19, 2010- Attention Nursing Facility Providers: A Reminder to Nursing Facility providers to verify the beneficiary's age is valid for the diagnosis code billed. Claims will pend if the age of the beneficiary is not valid for the diagnosis code being billed.

February 19, 2010- Attention All Providers: Please be advised that the Third Party Liability Division has begun processing the 'Pending Claim Adjustment' reports that were sent to Providers in July, August, September, October and November 2009 as well as any outstanding claim adjustment letters. The claims will be adjusted over a period of several weeks to lessen the impact on the Providers. Please refer to the 'Pending Claim Adjustment' reports or the claim adjustment letters for contact information should you have any questions or concerns.

February 19, 2010- Claims submitted via paper will suspend for processing. MDCH recommends providers use the CHAMPS Direct Data Entry (DDE) tool for claims currently being submitted via the paper claim form. Submission through the DDE system will result in a faster turnaround time. Providers can contact the CHAMPS Helpline at 888-643-2408 for assistance on how to use this tool in CHAMPS.

February 19, 2010- Attention Dental Providers: MDCH continues to receive many dental claims in which the Rendering/Servicing Provider NPI is being incorrectly reported as the Billing Provider. All dental claims must report a Billing Provider (Type 2 NPI) in F.L. 49 and a Rendering/Servicing (Type 1 NPI) in F.L. 54. Claims submitted incorrectly will be denied.

February 19, 2010- Attention Nursing Facility Providers: MDCH is current in processing the Medicare Advantage (Medicare Part C) Nursing Home claims.

February 17, 2010- Attention All Providers: CHAMPS will be unavailable March 25th-30th. During this time enrolled providers may contact the CHAMPS Helpline at 888-643-2408 to verify member eligibility.

February 9, 2010- Attention Hospital, Nursing Facility Billers : MDCH would like to remind providers that Admission Source is a required field. Claims missing the Admission Source will deny.

February 9, 2010- Attention Clinic and Special Programs (i.e. FQHC, LHD, MIHP, FP, etc.) Issues Resolved: Agencies with a single NPI for multiple clinic and/or special program specialties can bill for all services including MIHP. Agencies can bill for blood-lead related services and hearing and vision screening for children 3-6 years old whether they are enrolled in fee-for-service Medicaid or a Medicaid health plan*. Agencies can also bill for MIHP services provided in the home and receive the appropriate rate*. Billing NPIs that experienced denials because their enrollments were changed from Group to "FAO" enrollments have been able to bill since January 22nd. Some of the rendering providers from the group enrollments were not re-associated to the new FAO enrollments so some denials occurred between January 22nd and February 2nd for that reason. MSA's Provider enrollment staff have since added the missing associations but providers are encouraged to review both their rendering and billing NPI enrollments to ensure their accuracy.

Now that these issues have all been resolved, we recommend that each agency begin billing these services slowly with a small batch first and then larger batches after those claims. If submitted through the data exchange gateway by 5pm (the way that most billing agents like Netwerkes submit their claims) the claims will adjudicate overnight. If submitted by batch upload by 5pm the claims will also adjudicate overnight. If submitted by Direct-Data-Entry via the CHAMPS screens the claims are adjudicated within

15 minutes. Pay-cycle cutoffs are generally on Tuesday at 5pm for DEG and batch upload and Wednesday at 4pm for Direct-Data-Entry.

February 2, 2010- **Attention Nursing Facility Providers:** MDCH is automatically suspending Medicare Advantage nursing home claims for manual review. MDCH understands this is a timely process, but it is required to ensure claims are paid correctly. MDCH asks for your patience and assures you that every effort is being made to process effectively and efficiently.

January 29, 2010- [MDCH Paycycle Calendar](#)

January 14, 2010 - **Attention Outpatient Hospitals/Billers:** MDCH has completed the testing and implementation of the October APC software and pricing updates in CHAMPS. Providers can now rebill for any claims rejecting with DOS on/after 10/1/2009 with the H1N1 procedure codes and/or claims rejecting with October 1st new ICD-9-CM diagnosis codes. MDCH will be reprocessing all CHAMPS adjudicated OPH claims mid to late February to resolve numerous issues with OPH editing and pricing since CHAMPS go live. Please continue to check the CHAMPS website for upcoming information and updates.